SHRC working papers 3

# Executive Summary

Report of a Study on
Issues of
Workforce Management,
Rationalisation of Services
and
Human Resource Development
in the
Public Health Systems

Of Chhattisgarh State

# Strengthening Public Health Systems

SHRC
Working Paper 3

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**STRENGTHENING PUBLIC HEALTH SYSTEMS**

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# Foreword

There is increasing recognition that the challenge of providing universal access to quality health care requires primarily the building up of robust health care systems. In the context of a socio-economically challenged state like Chhattisgarh the foundation on which such a health care system rests is necessarily a strengthened, effective public health system. And strengthening the public health system requires a systemic approach. A systemic approach implies that in parallel to making investments in infrastructure, manpower, equipment and supplies there must be the development of management and professional capabilities and the development of appropriate organisational strategies and that all these must develop in parallel to each other. The Health Sector Reforms under the Sector Investment Programme constitute a major effort to stimulate and catalyse this sort of health system development.

This study on workforce management and rationalisation of services and human resource development in the public health system done by the State Health Resource Center is a welcome addition to the existing studies done in this area. This study builds a baseline of current state of health services in the state, documents current organisational practices and their lacunae and evolves a set of pragmatic recommendations. This study has also examined with compassion and understanding the factors affecting the motivation of cadre at different levels.

Some of these recommendations are innovative and lend themselves to immediate implementation with existing resources . A follow up study that defines the financial implications of these recommendations and makes the case for more budgetary allocation as well as suggests measures for supplementary resource generation would go a long way to facilitate the implementation of many more suggestions of this study.

Some of the major recommendations of this study -like on transfer policy and tenure- are reiterating well-known issues and remedies. Their implementation rests on the ability to negotiate acceptance by the political leadership of the state. Finally the far reaching recommendations for legislative policy initiatives would move us closer to the realisation of health care as a constitutionally mandated basic right of citizens. This would require much more discussions not only within governments, but within civil society as well, for generating the political will for such a step. Considerable legal, administrative and financial detailing would be needed before such a legislative initiative can take place.

I need to congratulate the department of Health of Chhattisgarh for its dynamic leadership of the health sector reform programme and we look forward to a rigorous and analytic documentation of their experiences so that we can learn from them and replicate successful strategies. I also appreciate their decision to invite consultants to assist a state level team led by the State Health Resource Center to do a study of this magnitude so as to build state level capabilities in policy studies. Their action in having had a serious dialogue with all stakeholders before finalising the recommendations is also worth emulating. I hope this study is widely shared at all levels and contributes to the health sector reform process not only in the state of Chhattisgarh but in all the Empowered Action Group states.

I am sure that this excellent report will galvanise the leaders and administrators of the primary health care system in Chhattisgarh state, enabling them to go into details of implementation based on the lessons drawn from this study.

PRASANNA HOTA
Secretary to Govt. of India, 2004
Dept. of Family Welfare

## INTRODUCTION

The formation of a new state provides new opportunities. The Government of the State of Chhattisgarh is engaged in the process of re-assessing the public healthcare system to arrive at policy options for developing and harnessing the available human resources to make greater impact on the health status of the people. As part of this effort the present study attempts to address the following three questions:

1. How adequate are the existing human and material resources at various levels of care (namely from sub-centre level to district hospital level) in the state; and how optimally have they been deployed?
2. What factors contribute to or hinder the performance of the personnel in position at various levels of care?
3. What structural features of the health care system as it has evolved affect its utilisation and its effectiveness?

From this the situational analysis the study proceeds to make recommendations towards a policy on workforce management, with emphasis on organisational, motivational and capability building aspects. It recommends on how existing resources of manpower and materials can be optimally utilised and critical gaps identified and addressed. It looks at how the facilities at different levels can be structured and reorganised.

The study used a number of primary data components – a questionnaire based survey of facilities that was applied on a sample of 128 subcentres, 64PHCs and 32 CHCs, a questionnaire based survey of organisational and motivational aspects that was used to gather data from 356 employees of 8 cadres, a number of field visits and focal group discussions, interviews with senior officials and self administered questionnaires of senior officials. We also studied the secondary data made available.

All the draft recommendations on workforce management and rationalisation of services were then discussed with the stakeholders. We identified four types of stakeholders. The employees and their associations; the officers at the national, state and district level, the medical profession and professional bodies and civil society. Based on these discussions the study group clarified and revised its recommendations and the final report was finalised . The main report has 75 tables and statistical information from both primary and secondary sources. For easy readability we have kept numerical data to a minimum in the executive summary.

We note that the last three years the department of health in Chhattisgarh state has seen a lot of new developments. A considerable expansion in manpower, a considerable improvement in both drugs and equipment position and a considerable improvement in many health indices. However the constraints that the system has inherited are considerable. A larger plan to reach a basic set of services for each level of the three tier health care system is needed. We have tried to chart out the contours of such a plan and project an approach to reaching it. In doing so we may be unfair to all the work that has gone into improving the system, especially in the recent past. The purpose of this analysis is not to apportion credit and blame .In the larger interests of improving the system the aim is to set out all the lacunae in workforce management and rationalisation of services, explore its causes and set down the possibilities for immediate and long term action to improve and streng-then it

## SITUATIONAL ANALYSIS

### ❒ Adequacy of "Sanctioned "Facilities

As per existing norms one HSC is planned for every 5000 population, one PHC for every 30,000 population and one CHC for every 1, 00,000 population. For tribal areas the norm is one HSC per 3000 population, one PHC per 20,000 populations and one CHC per 80,000 populations. The table-1 shows at a glance the current situation regarding adequacy of facilities.

The largest gap is in the number of sectors without PHCs- a total of 238. We also have a major gap in CHCs where in practice the norm followed is one CHC per administrative block. Due to this, large administrative blocks with population significantly higher than one lakh (or 80,000 for tribal areas) would have inadequate CHC coverage.

One problem in defining adequacy of centers (in study design and in the system itself) is that though a lot of facilities have been upgraded in designation, the corresponding increase in facilities and services has not followed at the same pace. The upgradation is a welcome commitment to increase services, but along with upgradation a clear commitment of when the desired level of services would be achieved should be stated. Such definitions and norms of the services to be delivered exist only at the sub-centre level.

**Table - 1** Adequacy of Health Care Facilities

| District | Popn. | Blocks | CHC | Av popn./ CHC | PHC | Av Popn / PHC | Sector | Av Popn/ Sector | HSCs | Av.Popn /subcentre |
|---|---|---|---|---|---|---|---|---|---|---|
| Bastar | 1302253 | 14 | 10 | 130225 | 54 | 24115 | 65 | 20034 | 317 | 4108 (3789) |
| Bilaspur* | 1993049 | 10 | 10 | 199305 | 49 | 40674 | 66 | 30197 | 303 | 6577 (5409) |
| Dantewada | 719096 | 11 | 9 | 79896 | 34 | 71909 | 47 | 15299 | 204 | 3525 |
| Dhamtari | 703569 | 4 | 2 | 351785 | 14 | 50255 | 24 | 29315 | 139 | 5062 |
| Durg* | 2801757 | 12 | 10 | 280175 | 48 | 58370 | 65 | 49104 | 353 | 7937 (5543) |
| Jangjir-Champa | 1316140 | 9 | 6 | 219357 | 22 | 59825 | 46 | 28612 | 211 | 6238 (5678) |
| Jashpur | 753096 | 8 | 7 | 107585 | 25 | 30124 | 33 | 22822 | 212 | 3552 |
| Kanker | 651333 | 7 | 6 | 108555 | 24 | 27138 | 34 | 19156 | 161 | 4045 |
| Kawardha | 584667 | 4 | 4 | 146167 | 10 | 58467 | 19 | 38978 | 101 | 5789 |
| Korba* | 1032432 | 5 | 3 | 258108 | 29 | 35601 | 44 | 23464 | 195 | 5894 (4468) |
| Koriya | 585455 | 5 | 4 | 117091 | 18 | 32525 | 23 | 25455 | 124 | 4721 |
| Mahasamund | 943527 | 5 | 4 | 235881 | 15 | 62901 | 37 | 25500 | 149 | 6332 |
| Raigarh | 1265084 | 9 | 7 | 180726 | 38 | 33291 | 35 | 36145 | 245 | 5164 (4473) |
| Raipur* | 3009042 | 15 | 12 | 250753 | 44 | 68387 | 89 | 33809 | 458 | 6569 (5235) |
| Rajnandgaon* | 1281811 | 9 | 9 | 142423 | 22 | 58264 | 36 | 35606 | 214 | 5990 (4910) |
| Sarguja | 1970661 | 19 | 18 | 109481 | 64 | 30792 | 85 | 23184 | 507 | 3887 |
| **Total** | 20795956 | 146 | 121 | 171867 | 510 | 40776 | 748 | 27952 | 3893 | 5342 |

*Source: Secondary Data: District Reports with Directorate Health Services*

* Urban areas skew figures; for HSC(subcenter) figure in brackets shows situation after adjusting for urban areas.

## ❒ Location of Facilities with relation to access

Amongst existing facilities there is considerable loss of utilisation due to improper location and improper distribution. The demarcation of sectors and sections are given to considerable maldistribution. And this is compounded by improper choice of village within the section or sector and the choice of venue within the village. Sub-centers and then PHCs were most affected by such poor location. The existing process of choice of venue is flawed and a specific alternative policy on this is required.

### ❒ Outreach Strategies to Enhance Access

Lack of roads and transport facilities and natural obstacles and high degree of scatter of hamlets within a section or sector add to the problems of access. These problems are not remediable by increasing facilities beyond the norms. Instead they need a high degree of community support and a high degree of planning and rationalisation of the work of the various categories of staff already available.

RCH camps are the major outreach strategy aimed to close outreach gaps but their effectiveness and even their occurrence in most areas is far from certain. A variety of other camps for different vertical programmes take effort and expense to organise but with uncertain benefits. They do mean a significant workload increase and loss of focus on key tasks. The thrust of outreach strategy today is for female paramedical workers to cope with the basic tasks through informal arrangements with local volunteers who are often the residue of earlier programmes - link workers, depot holders, community health volunteers, Jan swasthya rakshaks etc. This voluntary cadre appear to be playing significant support roles to the paramedical worker even though much of these roles are officially not recognised or budgeted for. The Mitanin programme has attempted to build on this dimension and provide a well-supported cadre of trained volunteers in every hamlet. The integration of this force with the sub-centre's function offers the best scope of advance in improving outreach.

### ❒ Adequacy of Staff and their Utilisation with Relation to Functionality of Centers

Female paramedical staff is near adequate in numbers. There are serious shortfalls in all other staff. A converse dimension of this situation is that of all the paramedical staff, only the female multipurpose worker and to a lesser extent the sector supervisor female shares the greater part of the workload. All other categories of staff at HSC and PHC level are characterised by poorly designed work schedules and are poorly utilised with a high degree of redundant work time. Rationalisation of paramedical worktime offers therefore the most effective route to addressing staff adequacy.

The current work description of the MPW female is unrealistic and is being coped with by developing a focus on just one or two tasks and informal local arrangements. As a result a number of essential services are completely left out (e.g. early recognition of child- hood pneumonia or proper treatment of diarrhoea or adolescent health care etc) and the quality of a number of other services, like antenatal care are seriously

compromised. (Almost no pregnant woman has her BP taken and blood and urine examined!!)

### ❒ Rationalisation of Drugs and Consumables Supply

The essential drug list is not being implemented. The main deficits are a failure to procure the entire items of the list, a failure to send samples for quality control, and a failure to exclude drugs not on the list. Other elements of the drug policy are also not in place. Thus procurement is sporadic, occurring once or twice a year with quotas to peripheral facilities to distribute the drugs. There are numerous breaks in supply and the distribution system is unresponsive to changing needs. Restriction of drugs to a narrow spectrum and breaks in supply are not even perceived as serious within the system reflecting poor perception of quality of care issues. The problem with consumables is even more serious than with drugs. Laboratory chemicals seem the worst affected but even gauze and bandages, needles and needle holders could be in short supply repeatedly.

### ❒ Rationalisation of Equipment

In equipment we have two types. We have relatively low investment "minor equipment" like Sahli's Haemoglobinometer or BP apparatus and infant weighing machines, which, if used, will need replacement frequently.

And we have more costly "major equipment" like ECG ultrasound and X-rays, which require replacement less, (upto once in five to ten years), but which require trained manpower to operate and often- considerable consumables as well.

In minor equipment we find considerable under-utilisation, and simultaneously reports of non -availability. Due to quality of care issues many of these equipment are not utilised. But equally there is a problem that if they are used many of these last only one to three years and then would need replacement, for which no ready system of purchases and restocking is available.

In major equipment the main problem is mismatches, between equipment supply and manpower to use it( e.g. ECG machines without anyone who can operate it), between equipment supply and level of services currently provided at that level (e.g. six neonatal care units supplied to a facility where there is no Caesarean sections or even as many normal delivery neonates per month, Colour Doppler equipments supplied where there

is no cardiology or cardiothoracic surgery capability etc.), between equipment supply and consumables available to use it( eg X-ray machines running out of film) and between equipment purchase and maintenance. At one level all such mismatches are attributable to failures of concerned officers. But at another level it points to a governance/ administrative failure, with one committee maximising purchases, and another set of persons looking at distribution, and no one looking at training and maintenance or eventual utilisation of equipment.

❒ **Infrastructure Adequacy**

The shortfalls in basic availability of buildings are well known. It is in the range of 62% for HSCs and about 34% for PHCs. CHCs are all in government owned buildings but as yet only an estimated 35% are upgraded to the 30-bed CHC norm. Toilet construction and maintenance too are major infrastructure inadequacies. Maintenance of buildings are also poor and most buildings are old and need extensive renovation or replacement.

Problems with electricity supply are minimal and generator back up is usually available where there are problems. Problems with water supply are however considerable. Most of these facilities have a bore-well and hand-pump so that they are functional. However any hospital with inpatient facilities, even if it were for only conducting normal delivery would require running tap water, bathing facilities and toilets separately for staff and for patients. Yet only one third of CHCs and less than one fourth of PHCs have such a water supply arrangement. Waste management based on segregation of wastes with proper disposal of each category of biological waste is a relatively untouched area of intervention.

❒ **Service Conditions**

**(Transfer; Promotion; Financial burdens; Personal Security Accommodation for Staff )** - The lack of a transparent fair system of transfer is easily one of the greatest causes of workforce dissatisfaction and demoralisation. Some staff spend their lifetimes working in remote areas seeking and never getting a transfer whereas others perceived to be able to personally and unfairly influence decision making get plum postings throughout their careers. This makes less staff willing to serve in rural areas and when they are so posted do their task with such a deep-rooted sense of frustration and anger that the quality of the work suffers. The problems of doctors not willing to serve in rural

areas should be seen only in this context and should not even be raised against the medical profession unless a basic transfer policy has been put in place.

Promotions need to be regular and timely and fair. There have been almost no promotions for the last three years in this state. This has led to a situation of deep dissatisfaction that runs through the entire department. It has also meant that all positions of authority starting from the top most and proceeding through the CHMOs upto the BMOs are held in an adhoc and arbitrary manner. Further the opportunities for an active career plan for a talented doctor or one who is able to work hard and perform more are absent. Considerable possibilities for non-medical and even non-service incentives that can be given to a doctor have been left unexplored. For paramedical staff too the lack of any possibility of a promotion let alone a career plan acts as a great demotivation from taking any initiative. These are all remediable aspects that need to be urgently attended to.

One nagging problem is the significant amount of expenditure that is being required to be spent out of pocket for staff, especially junior most staff, for what are clearly official functions. The main problems relate to travel allowance and stationary. This needs to be remedied at once, starting with the stationary expenses of MPW Females.

Another major problem is personal security, again a problem maximal with MPW females. Violence and sexual harassment, covert and overt affects about 10% but creates a sense of insecurity in all.

Another basic service issue is accommodation. At no level is there adequate housing for all staff. The focus has been on developing government housing for doctors first. At the CHC level there is accommodation available, especially for doctors but it is seldom adequate to house even half the staff or even half the number of doctors. At the PHC, most do not have accommodation for doctors and only about half have usable accommodation for other categories of staff. In many of these locations, availability of basic quality rental accommodation is also a problem.

### ❒ Laboratory Services

Laboratory services at the sub-centre are absent. By norms four basic tests- Blood pressure, weighing of pregnant women and children, blood haemoglobin estimation and urine testing for sugar and albumen ( also ESR) are expected to take place here.

These above tests however do take place infrequently in PHCs but even here they are not regular. That the PHC, as per norms, has a basic laboratory which can do about 20 basic diagnostic tests, has almost been forgotten within the system. Even microscope availability is low. In the last three years there has been considerable movement forward in this area and now availability may approximate 30% of PHCs - still a low figure.

In CHCs the laboratory is active but performs almost exclusively two tests, the blood smear examination for malarial parasites and the sputum examination for AFB. The list of desirable diagnostics at the CHC level is over 40 tests. Where CHCs are active the workload of these two tests are heavy (as no tests are being done at sector level) and this crowds out the possibility of doing any other laboratory investigations except the four that are to be done at the HSC level. Also as a consequence, the 'smear taking to report reaching back' time gets lengthened considerably (on an average 15 days to a month). With such delay this entire workload on the laboratory brings no additionality to health service outcomes. The blood smear examination has increasingly taken the form of a "modern" ritual denoting medical care devoid of content.

There is no major perception of the lack of laboratory services as a serious lacunae- again reflecting on the weaknesses in understanding and lack of emphasis of quality issues in medical care.

❒ **Referral Services**

The current referral services have two forms. Firstly there is a fund placed at the disposal of the panchayat for use to hire /pay for transport to shift needy patients to a hospital. There is an understanding that this must be used for high risk and complication of child birth. Funds flow and even awareness of this provision in panchayats is low and because of other structural constraints( lack of vehicle, inability to call vehicle in time etc) its utilisation is very low even as the need for referral goes unanswered.

The other referral is the patient being asked orally or with a slip to go seek treatment at a higher centre. This brings no advantage to patient or to the system and is perceived by patient as the referring facility having deliberately or otherwise failed to deliver its services. There are no clear norms for what is to be referred and when and there are no mechanisms to monitor referral to reduce unnecessary referral and insist on necessary ones. There is no feedback of any sort. In sort there is no "referral system" in place.

### ❒ Integration with ISMs

There is a large manpower in ISMs available in the state level and more pertinent in the districts. Their utilisation for public health goals is minimal. The utilisation of their Indigenous curative care services is also minimal. Their integration with the public health system is far from achieved. The bottleneck is not their willingness. The members individually and as a department welcomes such role allocation. However the administrative unification at the district level and the programmatic synergy at the level of programme design have not been planned for.

### ❒ Training

Training programmes are few and are driven exclusively by the vertical health programmes of the day, largely funded from external donors or the central government. As a result whatever trainings are taking place are arbitrary in choice of trainees and fragmented as strategy. Most training programmes are of one or two days and relate to a single disease and an immediate campaign for example a one day leprosy training or two days on HIV family counselling or one day on blindness control and so on. Some persons have received many such training programmes in diverse areas while some have received none. Then again all MPW( F) had a special round of training in RCH but neither their supervisors nor male MPWs were exposed to this. The vertical orientation of training leads to closely associated work of other diseases not being taught- even in much longer capability building trainings. Thus sector supervisors were trained on blood smear examination for malarial parasites but doing a differential count on that same slide would not be emphasised.

Almost no training is based on building competencies to attain a level of clinical service in a given facility. We therefore have a situation where there is a perception within senior officials that the system is being flooded with training programmes. Yet the system cannot guarantee that in the sub-centers or PHCs or CHCs of a given district. the level of knowledge and skills needed is now available. It may not even be able to state, facility-wise what level of skill building has been achieved and what are the gaps.

All these problems can be said to be true of IEC also.

## ❒ Structural Issues

### ◆ Governance

It is not adequate to locate all problems only at the administrative level. Some of the key administrative decisions are often taken at the political level. Of these transfers, promotions and purchases, which are purely administrative activities, have in practice become central areas of political decision-making.

The policy frameworks for the state remain weak. Most current practices in administration are inherited, having been handed down as traditional practices, rather than having been shaped by active policy frameworks that guide decision-making. What policy initiatives have been taken remains weak in implementation. For example the essential drug list is adopted but purchases have not been guided by it.

Another illustration relates to senior appointments and tenure. If a policy has to be implemented then a capable person or team must be put in place, monitored, allowed the time frame for that person to show results and the person must be changed if he fails to deliver. This requires a clear transparent system of senior appointments, a secure tenure, a clear set of goals and mandate for the person to achieve and periodic review of the same. We note that in contrast to this ideal all incumbent officers – the directors, the joint directors, the chief medical officers and programme officers of the districts and the block medical officers are all holding their current posts in an officiating capacity. Appointments become a prerogative of power and influence. There is no surety of tenure. Regular promotions and appointments at senior levels have just not happened. Administrative arbitrariness in such areas are to be recognised as indicators of poor governance.

Significantly even recruitments that are to take place through the Chhattisgarh State Public Service Commission are not happening though the public service commission has been constituted. Fresh recruitments have been therefore only contractual, even where there are vacant posts. This is again an issue of governance.

The problem is that there is a cynicism about policy-making itself. There is a feeling, often justified by experience as with the essential drug list that anything can be passed as policy statement without any binding on its implementation.

Normally the ministry would lay down policy and the directorate would be answerable for its implementation. The ministry would be the main vehicle of ensuring accountability and transparency of the directorate and be answerable to the legislature for it. The creation of a state health society is meant to facilitate, not weaken this relationship. However when the separation between governance and implementation is lost and the ministry itself is responsible for implementation, as in the current nature of the state health society, or when the ministry is unable to ensure policy based implementation in core administrative areas, then health sector reform goes beyond the administrative realm to that of the reform of governance. One would then have to look to the legislature, the judiciary and institutions of civil society to ensure accountability. The question we pose is that in the core administrative areas – tenure, transfers, promotions, purchases, and transparency is it a technical and managerial failure or a failure of governance? If it is an inability to formulate a transfer and promotion policy or organise a system of purchases then it is a technical and managerial issue. If not, it is a failure of governance.

- **State Level Work Organisation**

The distribution and management of work at the state level was one of the areas of interest for the study. The state has four directors- one for medical education, one for Indigenous systems of medicine, one who looks after food and drugs control all of who have limited well- defined portfolios and the director of health services(DHS) who looks after all the rest. The DHS looks after recruitments, promotions, purchases, infrastructure development, programme planning, programme reviews, training programmes, regular establishment functioning, and is in-charge for externally funded special programmes, and in effective charge of the state health society and is reporting authority for all district CMOs and so on. In this he is helped by a number of joint directors who have relatively well marked out specific areas- one for tuberculosis and leprosy programmes, one for establishment, one for blindness control and epidemics. All other programmes are managed directly by the director with the help of deputy and assistant directors and clerical staff. Almost all of the senior officers are more in the nature of supportive staff to the director and there seems to be little financial or administrative action that they can independently take and implement. The inability to de-concentrate powers and responsibilities at this level is a key problem and may be the main reason for being unable to keep to project schedules. A comparative study across the states may help establish this.

A related dimension is the need for professionalisation at the state leadership level. Though they have very relevant practical experience, professional training in public health management, health policy and in hospital administration has been weak. Epidemiology is a seen as a separate speciality area- not as something basic to health planning and few are conversant with its methods. Administration would be perceived as nothing more than knowing the rules and common sense. There have been serious efforts in improving this situation by training inputs, but these are minimal and for this level of leadership, rather too late. A medical administrative state cadre has been suggested but not followed up seriously. Even in relative areas of pure management and administration like infrastructure development and purchases and logistics, the system has not made use of qualified management skills, which are easily available on the market.

- **Decentralisation**

Yet another major issue is of decentralisation of powers to districts. Currently all district officers perceive districts as having very limited powers – in all of the above aspects of administration as well as in training and programme planning. Indeed for the main part they are only implementing agencies for national health programmes. The district administrative team can be said to consist of the district CHMO, the civil surgeon the programme officers and the block medical officers. Their own terms of selection, transfer and monitoring have all the same organisational and motivational problems common to other sections and it seriously compromises their work output. Thus while decentralisation of powers and finances is essential, it needs to be done in the context of these key administrative reforms being carried out.

Currently elected panchayats have a negligible role in the health sector and even in this the support and programme design needed for them to be effective is not available.

## Related Issues : Unfinished Study Agenda

The study recognises that the **financing of health care** is an important issue and that budgetary allocations on each facility and workforce relate to outcomes. Also that what is adequate utilisation or wasteful relates to amount of investment that has gone into it. These financial aspects are the subject matter of the subsequent study.

**Mapping the private sector** and exploring its possibility of synergy with the public health system and developing a policy framework for its growth and regulation are yet another issue that we have not addressed.

**Urban health** is another major area where the study has not focussed attention. There is already a realisation that health care for the urban poor and public health programmes in the urban context are grossly inadequate and there is an urgent need to develop viable cost effective models of health care delivery.

The study also notes its limitations in not having examined the functional status and **design of specific health programmes.** These are closely related to workforce issues and allow consider scope for rationalisation. Such programmes include the various national disease control programmes, the reproductive and child health programmes and the strategies of epidemic management.

Finally there is a case for a detailed examination for current **IEC strategy,** one of the most important dimensions of public health strategy. This is being by Danida Support Units guidance and we have not repeated it here.

# RECOMMENDATIONS

## I. ADEQUACY OF FACILITIES

- **Increasing Numbers of Peripheral Health Facilities.**

  In the number of Health Sub-centers there has been considerable progress made and almost all sections have sub-centers.. Now the urgent need is to focus on :

  - **Increasing PHCs to ensure that there is a PHC in every sector.** This means a plan to create 238 more PHCs within this five year plan period.
  - **Increase peripheral health facilities in urban centers** i.e. create a comprehensive urban health plan which would include a network of urban health centers.
  - **Increase number of CHCs so as to conform to population norms.** Thus we need to have at least one per block supplemented in large blocks by upgraded PHCs which would eventually become CHCs. That is some of the PHCs are to be upgraded to 24 hour 6 to 10 bed hospitals with emergency care. Thus we have about 120 CHCs in 146 blocks- whereas we need about 180CHCs or upgraded PHCs in all.

- **Adoption of Minimum Norms of Service Delivery & Provisioning for it**

  One of the most important recommendations of the study is the adoption of recommended norms on service delivery for each facility- the health sub-centre, the PHC, the CHC and the civil and district hospitals. These norms may be widely disseminated and must inform all health sector reform planning. ( the recommended norms are given in annexure 2 of the report). The norms themselves can be subject to change but at any given time there must be such a norm in force and a due process for change of norms with adequate space for representation in this process by stakeholders. Action in this has already been initiated with the publication of standard treatment guidelines for medical officers which incorporated these norms and is based on it.

## II. PROBLEMS OF LOCATION OF THESE FACILITIES

- **Block level Mapping : GIS based :** It is required to prepare block level maps showing all villages with existing HSCs and PHCs in all blocks as well as demarcating various sections and sectors according to population norms fixed for areas with primitive populations, tribal populations and non-tribal populations. Based on this to search out ideal locations for HSCs and PHCs as and compare this to where they are currently. This may be most efficiently done on GIS based software created for this purpose.
- **Optimum location of facilites :** This would consider geographical optimum as also take into account economic activity, like the village weekly market and locate the centre in tandem with such activity so as to make it easier and more likely for people to access the sub-centre. This may be included as a parameter in the GIS data base. This data base may also reflect location preferences with a quick stakeholder analysis.

- **Re-location Possibilities :** Based on the above inputs decide on location at first for all facilities where government constructions are needed like in HSCs without buildings, Sectors without PHCs, vs. Sectors with PHCs operating from rented buildings. Where necessary infrastructure has already been constructed these facilities may be classified into those that are by location completely unusable; those that may be continue to be used unless there are alternate uses for the current building and funds to build one at ideal location, and a third category where current location of facilities is acceptable. Based on this a plan of construction priority for each block may be drawn up.
- **Constructions only according to Plan :** Once such a plan is drawn up for each block funds may be sought from internal budgetary mechanisms and from external agencies, insisting all the while that all constructions must be in accordance with the plan. The approval of designs of the buildings and the construction would be done at the district level under approval from the empowered body which is made at the state level to look at purchases maintenance and infrastructure development.
- **No 100 bed hospitals :** in any block or district may be built till all district hospitals and all CHCs staffed and functional as envisaged.

## III. RESTRUCTURING STAFFING PATTERNS, REDEFINING JOBS AND ADEQUACY OF MANPOWER

- **Re-calculating Manpower Gaps :** Gaps in staffing should be recalculated after planning for multi-skilling and redistribution of existing staff such that there are no redundant manpower.
- **Two female MPWs in each Subcenter :** Sub centers may plan for two MPWs, preferably both women. The job description and workload of the MPW (F) needs to be lessened and made realistic. Along with this, workload rationalisation would be achieved by equal sharing of the work between the two persons posted at the sub-centre. In the first stage this is achieved by redefining the male MPWs work to be identical with the female MPWs. Except for institutional delivery and IUCD insertion, every task currently done by women can be done by men also. And in the second stage by ensuring that the second person in the HSC is also a female MPW i.e. converting the male MPW post to a female MPW post.. In effect this would mean that the population per MPW-Female norm currently at 1: 3000 in tribal areas( or 1 : 5000 in non tribal areas) would fall to 1:1500in tribal areas ( or 1:.2500 in non tribal areas ) at same costs to the system. Without increasing costs or number of sub-centers we would be doubling the density of the most active, effective and critical workforce of the entire system
- **Multiskilling all PHC paramedicals :** The PHC staffing pattern needs restructuring to ensure utilisation of manpower and better functioning of the facility. PHCs may plan for having two or three male multi-skilled employees with a male multi-skilled supervisor and three female multi-skilled workers (including the section incorporated in the sector) and a female multi-skilled supervisor. There would also be one medical officer in every PHC (preferably two). These multi-skilled workers must be skilled in dressing, drug dispensation (the compounder's task) and first contact curative care and in basic laboratory package as well as in RCH. Between them they should be able to keep

the PHC functional for 24 hours, provide institutional delivery and the other services as proposed in the service delivery norms. Though the immediate step is only multi-skilling and revising job descriptions, cadre restructuring may follow this. In this process of transition no one has to be dropped unless they are unwilling for multi-skilling. New recruitments would be into the multi-skilled category and many existing cadre would die away. Some like staff nurses would function as multi-skilled staffs when posted in a PHC and can play the role of staff nurse when posted in CHC and district hospitals. We estimate that such retraining and redeployment would solve a substantial part of the manpower vacancy problem. Each PHC may also have two staff at class IV qualifications.

- **Rationalization of Deployment Medical Doctors in the PHC Level**
  - **Differentiated Strategy According to Difficulty Levels :** The ideal would have been two medical officers at every PHC (as in Tamilnadu). However this may not immediately be realised due to shortage of potential recruits and the difficulty in finding even one medical officer per remote area. Therefore we suggest that PHCs be categorised into most difficult, difficult and easy and a different strategy be adopted for each.
  - **24 hour Multi-Skilled Paramedical Based Service in all PHCs :** We recommend that in all PHCs irrespective of category, 24 hour service with emphasis on institutional delivery be insisted on by multi-skilling and deploying paramedicals. The multi-skilled paramedical worker should also be trained in emergency care management at primary level. (We emphasise that by paramedical worker we mean the current MPWs or pharmacists or staff nurses currently in service with further training inputs and not the legitimisation of under-qualified allopathic practice that also goes by the name of paramedical course.). The role of the doctor in the PHC would be to provide leadership and on the job training and a referral back up for this team. Where a doctor is resident, the doctor is available on call 24 hours to back up this team.
  - **Daily Visits by CHC Based Doctors for Most Difficult PHCs :** Where no medical doctors are available currently, where access is a problem and accommodation facilities are low (category C), even as efforts are made to fill these posts, the backing up is done by daily visits and in a few distant PHCs two to three visits per week of a medical doctor from the respective CHCs. The doctor would be required to be available during working hours and his stay at the PHC would be insisted on only if adequate accommodation arrangements, governmental or rental are available. Even in this exemption may be given for special reasons as long as stay is in nearby block town as part of the CHC team and daily attendance is regular. Family accommodation at the CHC would be easier to organise. In other words we should not insist on medical doctors staying in PHCs designated category C- most difficult. (We consider that the above approach with mobile doctors but fixed facilities may be more cost effective than mobile hospitals when combined with the use of multi-skilled paramedicals.)

- **Strengthening BAMS Doctor's Role while keeping Medical Officers Option Open :** The use of medical officers with BAMS (Ayurvedic scheme) to fill up vacancies where no medical officers are currently available is welcome. However all the service issues discussed equally affect their functionality. Moreover currently they would be unable to deliver the notified services of the PHC level and special training would be needed to close the gaps. The post of the allopathic doctor may however be retained and the search to fill this post continue. If training and promotion polices are put in place these vacancies would certainly be much less. By integrating ISM sector with the allopathic sector we may also approximate the ideal of two medical officers per PHC much faster and have less under - utilised manpower in our hands.

❒ **The CHCs be Strengthened by**

- **Appointment of Six Medical Officers at Least,** four of whom at least are specialist or within them have the required four-skill (physcian, paediatrician, surgeon, gynecologist) mix. If there are a number of PHCs not having doctors to be looked after with visits, the number posted here may increase further. Currently the recommended norm is only four doctors per CHC, which is sub-critical.
- **Adequate Multi-Skilled Male and Female Paramedical Staff,** who can manage the necessary support work and multi skilled imaging technicians who can also manage X-rays, ultrasound and ECG too. In addition there would be a unskilled worker category of undifferentiated, interchangeable class IV function- chowkidar, peon, sweeper, waterman– all rolled into one. Four qualified staff nurses, two qualified laboratory technicians and an optometrist are also a must at this level.
- **Re-designating the BEE,** The block level extension educator may be renamed the block senior paramedical supervisor and be responsible for capability building, IEC and supervision of the sector supervisors.
- **Adequate Clerical and Accounting Staff,** at least two, be provided to every CHC along with a computer and printers.

## IV. RATIONALISATION OF WORK ALLOCATION AND APPROACHES TO IMPROVE OUTREACH

In addition to the above measures improving outreach would require :

❒ **Reorganisation of MPW Work Schedule**

MPWs may be required to tour for three days a week, instead of the present one or two days a week. One day a week should be devoted to review and drawing supplies from PHCs. The remaining two days a week should be devoted to clinical work and other services provided at the sub-centre. These two days are fixed and her clientiele should know that she is available there in her headquarters on these two days. In each field visit day, he/she would visit a specified number of houses and hold meetings with one of the four identified focal groups. Once a month he/she should attend to Block

level review and training. If there are two MPWs posted their two days at the headquarters may be fixed such that the sub-centre is open on four previously specified days every week, which is better than the current one day a week.

### ❒ Integration with the Mitanin Programme

It is extremely important to develop a mechanism to sustain interactions between MPWs and Mitanin. Such a mechanism is also required for the long-term success of the Mitanin programme. The Mitanin programme offers the scope to rationalise and the MPWs job responsibilities more achievable. The Mitanin's focus is on health education, family level counselling and prompt and adequate management of diarrhoea and acute respiratory infections. The Mitanin also maintains a register for her village which tracks each family to identify any specific health service gap and motivates the family to receive this service as she coordinates with the MPW to ensure that the service is delivered. If the gap is large then this may be achieved through Mitanin initiated health camps. The MPWs focus is on actual service delivery on RCH and in all national programmes – like immunisation, provision of contraception, care in pregnancy and assistance at delivery and soon and on support to Mitanins, anganwadis and panchayats.

### ❒ Revised MPW job Description.

An MPWs job description for both male and female worker would now read

- Immunisation- Children and pregnant women largely at the village visit and camps but supplemented by immunisation at he sub-centre.
- Ante natal care and post partum care at sub-centre, with visits to those pregnant women unable/unwilling to come
- Motivation and facilitation for all methods of contraception
- Training and support to Mitanin and local women's health committees.
- Regular house visits, such that every household is visited once every month (or two months in difficult areas) for a set of "case detection, follow up and counselling activities" along with first contact curative care where required.( this includes all national programme related activities)
- Focal group discussion/health education sessions/ health camps during village visits.
- Curative care during field visits on three days and at sub-centers on two days.
- Response to epidemic using a graded epidemic response protocol.

In addition to the above male workers would have the following tasks :

- Addressing male youth on adolescent problems and STDs control.
- Interaction with panchayats and with local leaders for facilitation of health programmes.

In addition to the above female MPWs shall have the following tasks :

- Assistance at child birth.
- IUCD insertion.
- Addressing adolescent girls on health problems.

### ❒ Outreach Camps

As a rule health camps are beset with problems. They are wasteful of resources, they disturb routine activity, they alter priorities of persons and problems attended to and they create a high visibility for relatively low priority and inadequate activities- mostly symptomatic or even irrational curative care for trivial illness. However in villages or clusters of villages where one or other service has had less than 50% coverage or there is a large number of persons to be reached - a health camp which reduces and brings down to a manageable level the burden of unfinished service delivery would be welcomed. Health camps therefore should be preceeded and driven by health needs identified by Mitanin (or MPWs or panchayats) rather than programme expenditure targets to be met above. Thus a blindness treatment camp preceeded by a careful identification of those needy and driven by such needs with a carefully planned follow up, or an immunisation camp for measles where a survey shows that over half the children have not received it, is much more useful than declaring a series of camps first and then trying to mobilise the clientele for it.

## V. RATIONALISATION OF DRUGS AND CONSUMABLES SUPPLY

### ❒ The Essential Drug List

The essential drug list needs to be implemented. In particular the expanded list of drugs adopted for HSCs and PHCs has to become available to them and at once. This is to be accompanied by training on standard treatment guidelines and a drug formulary for the expanded list, a process that has now begun. The essential drug list may also incorporate all consumables and minor equipment (frequently replaceable). A quick process of appeal can be built in where a CMO or programme director appeals for being permitted to purchase a drug outside the list, but this must be done only with prior permission and with due process. Upto 10% of the budget may go to such outside the list purchases. Any violation of the drug list should invite disciplinary action or else it would be difficult to get a meaningful drug policy into place.

### ❒ Distribution

Systems where pharmaceuticals, consumables and equipment flow in from district level warehouses to peripheral facilities in a routine manner are essential. A number of the equipment that MPWs use requires frequent replacements like BP apparatus and thermometers and they should also be therefore a part of consumables management. The drug and supplies policy should reflect this. We further recommend that a distribution system based on the "pass-book" like in Tamilnadu is urgently needed so that distribution can be all year around and responsive to patterns of usage. In this system each facility has a passbook, which reflects the amount of drugs in stock. When the stock falls to below three months usage, a level fixed at the district level for each drug then the facility immediately indents for the drug to the district warehouse which in turn supplies the drug to the PHC in the same week. When the district stock falls below a three months supply an order is sent off the next day and within a month the item would reach the concerned district warehouse.

- **Procurement**

  We recommend that the pre-qualification of suppliers and the price negotiation be done at the state level by an empowered body in a transparent and open manner. When the district warehouse stock falls below its three-month figure then the same drug is immediately procured at approved rates. Therefore all subsequent districts orders are through this empowered body and supplies would be sent directly to the districts. This body would arrange for quality testing of drugs also.

- **Drug Policy**

  All of the above should be incorporated in a separate drug and consumables policy. The adoption of such a drugs and consumables policy for the state is another urgently required policy measure.

## VI. RATIONALISATION OF EQUIPMENT- PROCUREMENT AND UTILISATION

- Smaller low cost equipment that is frequently replaceable must be dealt with as for consumables.

- Larger equipment, which is costlier and requires training to make operational needs to be purchased and deployed only as part of block and district level plans linked to service quality deliverables. This would ensure that there is no mismatch between equipment purchase and infrastructure, between equipment and skilled manpower available, between equipment and related consumables supply and that the purchase of equipment is linked to quality improvements in the package of services offered at this level.

- Purchase can have the same policy of pre-qualification and price negotiation at the state level with districts then placing orders. The same empowered body which implements drug and supplies procurement and distribution may undertake all equipment purchase. Further such a body would ensure that adequate arrangements are made for maintenance and such arrangements are renewed.

## VII. INFRASTRUCTURE ARRANGEMENTS

- There is an ongoing effort to build 30-bedded hospitals with a modern operation theatre in every designated CHC. This is a welcome effort and deserves to be strengthened. At the level of the block ensuring bed occupancy of these 30 beds is itself a challenge. Therefore the attempt to take on 100 bed rural hospitals is ill advised and would be diverting funds away from this basic goal which is far from complete.

- Given the large gap in infrastructure our recommendation is that a plan be drawn up for closing the gaps prioritising sector PHCs and CHCs and completely integrating with ISM infrastructure. Sub-centers would be only next in priority and institutional delivery in sub-centers need not be insisted on at this stage. Once the plan is drawn up one set of blocks be prioritised and the gap closed in that set of blocks along with closing equipment and manpower gaps before moving to

the next set of blocks. Thereby the entire infrastructure requirements for the state would be met over a five year period without having to face the gross under utilisation of infrastructure as is currently faced. If there are financial constraints to infrastructure devlopment the evidence of good utilisation would help to overcome them. Currently utilisation is so poor that both state finance departments and external donors feel justified in shying away from infrastructure investments. This coordinated development of infrastructure is the heart of the EQUIP programme's rationale.

- Attention may be given to closing the gaps regarding water supply and power supply and to ensuring that separate toilets for staff as well as bathing facilities for men and women are also in place in each of the PHC and CHC structures. Inadequately recognised priority areas are waste disposal systems, drainage and sewerage all of which needs to be put into place in all PHCs and CHCs.

- Telephones are one of the most immediately remediable problems and some urgency needs to be given to this issue. There is much effort at computerisation at state level and providing computers and web-access with training to use this would enhance monitoring and support capabilities tremendously. It should be possible to prioritise this and within a finite time frame achieve this capability at least for PHCs and CHCs and later for HSCs as well. Computerisation in the present day is also a culture that may be encouraged.

## VIII. SERVICE CONDITIONS

### Transfer; Promotion; Financial burdens; Personal Security, Accommodation for Staff

- **Transfer Policy**

A clear policy on transfer is a well-perceived and long overdue reform measure. This is needed for all categories of staff but particularly for the male and female multipurpose workers and heir supervisors and the medical staff. A committee composed of some senior officials, some motivated workers identified by the department and some representatives of the workers service associations should evolve such a policy that is considered fair, transparent and easy to implement at the earliest.

The following principles should be considered while developing the transfer policy

- Pressure for transfers would be reduced by making MPW selection into a block level cadre and other category selection including medical officers, other than Class-I officers into a district level cadre.
- The authority for the transfer shall be a district and state level transfer tribunals. The tibunal may be made up of a three-person board chaired by the Chief Medical and Health Officer of the district, with one of the board members appointed by the District Collector and another by the Employees Association.
- A roster of request for transfer should be maintained. Transfer shall be considered in that

seniority. Within the same transfer seniority, service seniority shall prevail.

- All cadres may apply for transfer stating their preferred choices.
- All postings in the district shall be classified into very difficult(C) and medium difficulty ( B ) and choice postings (A ). Every staff shall be required to serve roughly equal time in all these levels of difficulty.
- After ten years in one area transfer is mandatory as also a matter of right, but can be according to choice if the chosen post is vacant. Transfer out of a difficult area would not be mandatory but would be an employee's right if the required period of service has been given.
- Mutual transfers shall be allowed but without contradicting any of the above clauses.
- Persons in the last ten years of service may be exempted from mandatory transfer.
- All promotions may be considered only after five years in difficult posting or ten years in medium posting is completed

## ❒ Promotion Policy for paramedicals

- **Regular Prompt Promotion with Six Months Pre-Promotion Training :** Prompt promotion of MPWs to sector supervisors may be ensured. Before they take up the task as sector supervisors both MPWs male and female may undertake a six-month training programme. (Currently male supervisors do not have to undergo this training though women supervisors have to). There is a large backlog and urgency needs to be given to prompt implementation of these promotions.
- **Fast- Track Promotion :** We also recommend an additional system in which a portion of total LHV and male sector supervisor posts (25%) may be reserved for promoting MPWs on the basis of their willingness to serve in difficult areas if they had not done so in the past, and an examination of their skills and knowledge after a minimum period of service eg seven years of service.

We expect that this will motivate some enthusiastic functionaries to volunteer to serve in more difficult areas. If those promoted are not able to fulfil their commitment and get transferred to non-difficult areas before fulfilling their 5-year comment, their appointment as LHV/Sector supervisor will be revoked and they will reinstated as MPWs.

For those MPWs already in difficult areas, a promotion in this channel may induce them to continue their services in these areas.

We understand that in difficult areas multiskilled sector supervisors would have to play a major role in running 24 hour services at sector level ( see along with recommendation on multi-skilling in next sections).In such a context such a parallel channel where some younger more dynamic persons become available at the supervisor grade would be useful to initiate this process.

- **Redesignation of the BEE :** The Block extension educator does not do block extension education and may be renamed block senior paramedical supervisor. He would have a special responsibility in training, capability building, IEC and supervision. This promotion should be seniority cum merit promotion based on adequate testing of training capability from within the cadre of all sector supervisors who have completed a certain number of years.
- **One Time Bound Seniority Based Promotion for All :** For all other service categories promotions and benefits there shall be one time-bound seniority based promotion from selection cadre to senior cadre.

## ❒ Promotion Policy and Career Plan For Medical Officers

Negative attitudes to the service and to their work amongst medical officers must be recognised to be as a failure to understand and care for this cadre and due to poor structuring of health systems – not "lazily" blamed on the medical officers. The lack of transfer policy and frank discrimination in transfers is one important reason for demoralisation. The lack of promotion avenues is another. For doctors other than promotions the ability to enhance their skills, their prestige within the profession, their prestige in society and their contribution to science are all important motivational aspects that need to be provided for. Their inability to make a career plan where they can enhance clinical skills or get other promotional or career opportunities later is a problem. The system would reap rich benefits if it saw the desire for career advancement of the doctors as an opportunity instead of as a problem.

The key recomendation on promotions for doctors are :

- **Contractual appointments must be seen as adhoc arrangements.** Regular appointments may remain the mainstay of the workforce.
- **Timely, timebound promotions** to senior grades and specialist grades needs to be ensured.
- **Skill retention for specialists** The feeling of professional dissatisfaction may be higher especially in postgraduates serving as medical offices and needs to be addressed through better professional opportunities. Every postgraduate could be linked to CHCs, which they attend on periodic occasions for providing specialist services. Thus a surgeon should be able to perform operations on certain days and so on. And they should be able to send for investigations at higher centers directly and have access to drugs related to their field of specialisation, which normally we would not expect a PHC doctor to handle and so on.
- **Choice of stream for Class-I officers** After ten years of service when they enter class -I officer status the doctors maybe given a choice betwen a clinical stream( if necessary of a district cadre) or a state level adminstrative cadre with opportunities for advance ment professionally in both these streams.

### ❒ Financial Burden of MPWs

The department should provide for adequate allowance to MPWs to carry out routine paper work. Payments should be prompt and be made on half-yearly or annual basis.

Also, unfair reductions and false statements on expenses made on travel and other programme purposes should be eliminated. The assistance cell (discussed later) should be available for confidential complaints in this regard.

### ❒ Personal security : Creating a Women Employees Assistance Cell at District Level

This must be recognised as an issue for MPW females. The Supreme Court has already laid down the procedures under the VISAKA guidelines and these may be publicised and implemented.

We also recommend an Women Employees Assistance Cell in all districts that will provide legal aid, counselling and protection and some degree of grievance redressal particularly to the MPW female workers. The WEAC should meet every quarter and have a confidential postal access. It should take up all issues confidentially and in non-–confrontational manner. It should not hesitate to recommends firm administrative or legal action where necessary, with adequate publicity for it to act as a deterrent. The WEAC should be headed by a woman outside the health department –with some experience of work on women's issues. The WEAC should be nominated by the District Collector in consultation with the Chief Medical Officer.

### ❒ Accommodation

**Block Level-Government Housing Plan :** All accommodation for medical staff at CHC level should be part of a government housing development plan common to all government departments so that adequate supporting infrastructure and facilities can be developed. This can be done with private partnerships, not only to speed implementation, but also to bring in investment. The accommodation so provided should be adequate for all staff. Work could start with prioritisation of more difficult blocks so as to speed up development there.

**Sector Level-Category-wise Priorities :** All PHCs in medium category difficulty should be prioritised for building government accommodation, for all the staff in a cost effective manner. This would act as an incentive for staff to work there. In "most difficult" category areas accommodation maybe planned for paramedical staff as a priority at this stage.

**Sub-Center Buildings :** Sub-centre buildings may not be seen as a priority except where the complete block level planning is completed. It is best to prioritise those sub-centers where there are no rooms available on rent or alternate building available for developing infrastructure then only move to other centers. Since institutional delivery is not being insisted on at HSC level, rented accommodation with a stores and a consultation/immunisation room available and paid for by the

government should be adequate for most HSCs in the immediate period. When a new building is undertaken, the current design of MPW accommodation cum HSC facility may be continued even though institutional delivery is not insisted on as this space has other uses to merit its retention. Where needed and when the systems of referral have developed it may be easily be designated for institutional deliveries.

## IX. LABORATORY SERVICES

- **Multiskilled Cadre for PHCs :** Since the current number of laboratory technicians is adequate only to man the CHCs a greater effort should be made on multi-skilling other cadre to undertake this work at the sector level. Over a few years every support staff should have these basic skills.
- **Basic Set of Tests for PHC :** The basic laboratory set of tests provided at the PHC must include blood haemoglobin estimation, total count, differential counts, bleeding time and clotting time, blood smear examination for parasites, urine examination for albumin, sugar, ketones, bile salts and pigments, microscopy of urine, sputum acid fast microscopy, grams staining of sputum, Csf, stool microscopic examination for ova and cysts and hanging drop examination of stools. The sickling test may also be considered. All these tests require very basic skills and are easily taught. The most difficult of these is the BSE(blood smear examination) for malarial parasite and sputum for AFB but given that multi-skilling in this is already accepted, ability to train in this wider range of tests should not be considered a problem.
- **Training Approach :** This set of tests can be taught to a team member - primarily by the medical officer. Training programmes at the district level would only supplement this. The medical officer would only need a one week package to be refreshed on this if there is a good text to follow along with proper teaching materials organised well. Charts and guidebooks that both doctors and multi-skilled staff can refer to along with pictures of microscopic appearances should also be available in every centre and their absence is a serious remediable problem.
- **CHC tests as Per Standard Treatment Guidelines :** The set of tests to be available in a CHC have been described as part of the state's standard treatment guidelines and service delivery norms. Broadly the CHC should be able to conduct the following diagnostics :
  - Basic blood biochemistry, and microscopic studies with grams stain, cerebrospinal, pleural, peritoneal fluid examination. Immunological testing esp. for hepatitis, typhoid, AIDS, and syphilis.
  - Basic imaging : X-ray, ECG and ultrasound be the norm for all CHCs.
  - Every CHC should also have the capability to take and send samples for microbiological cultures and histo-pathological studies at the district level where relevant.
- **Upgraded Laboratory Technicians at CHC :** The qualified laboratory technician at the CHC level should be upgraded to provide this much larger package of tests then what is currently available. Where still gaps remain public private partnerships to close these gaps may be prioritised. The laboratory technicians and the X-ray technicians should work under the supervision and guidance and quality control of a suitable district level officer in addition to the block medical officer.

❒ **Health Sub-Centre Level Tests :** At the HSC level urine testing for albumen and sugar and blood testing for haemoglobin should be implemented. In addition it should be possible to train a cadre of NGOs and "trainers of Mitanin programmes" and male MPWs to do BSEs and sputum AFB testing along with the above, thus reducing reporting time of blood smears to less than 24 hours, for all habitations. This would require investment by the government in a microscope and a basic kit and a piece rate payment arrangement by which these essentially private service providers can be remunerated for diagnostics done for the public system.

## X. REFERRAL SYSTEM

### ❒ Defining Referral Needs

The importance of a referral system cannot be over emphasised. Broadly, between the PHC and the CHC, or between the CHC and the district hospital, the following reasons necessitate the need for a good referral system :

a. For establishing the diagnosis for which laboratory investigation not available at the PHC/CHC are needed.

b. For establishing the diagnosis for which a second opinion or an expert opinion not available in the PHC/CHC is needed.

c. For management of case whose diagnosis is known and infrastructure, staff , equipment is adequate but for whom drugs are available only at the next level e.g. epilepsy.

d. For management of a case whose diagnosis is known but where a quality of equipment or infrastructure or staff is needed which is not available in the PHC- e.g. all in-hospital care or surgical care etc.

- Under condition a & b, referral is a one time event and with a good quality, prompt feedback the case can be further managed at the PHC level. This referral therefore enhances he quantity and quality of services provided by the PHC. Condition c is avoidable and requires that the drugs be available at the PHC. The new essential drug list has a number of drugs included in the primary health centre list so as to avoid such referrals altogether and if needed this may be supplemented by allowing special indents.

- Condition "d" may occur as an emergency or in routine outpatient circumstances. Some of these cases would need to be followed up at the higher level for all time to come. But many would be able to be sent back for follow up to the primary level once the acute crisis is over. Availability of this referral enhances the credibility of the PHC.

### ❒ Designing Effective Feedback in a Referral System

We can thus see that most of the above referral purposes need a referral system, the heart of which is the feedback arrangement to the primary level. If such a system is well in place the capabilities of the PHC and the medical officer there are dramatically increased. In our situation of illiteracy and low schooling and mystification of medial practice sending a note back with the patient is not

a reliable, accountable or effective referral system. In addition to sending the note back with the patient the feedback data on referred patients, whether it be expert opinion, or laboratory investigation, or instructions for follow up should be transmitted in writing through the health system and available for verification. Eventually this feedback should be electronically transferred through Web and Will systems.

### ❒ Block Level Ambulance Services

A good transportation system is essential for any referral system to function properly. It is suggested that in addition to the ambulance with the CHC a block level ambulance service be developed in partnership with local community organisations to transport patients and this be tied to the referral systems. It is also essential to construct a referral system between HSC and PHC and between Mitanin and PHC based on similar principles of specifying situations that need referral and arranging for a strong feedback mechanism. Good communication between different tiers is needed as well and this should be linked to the ambulance service.

### ❒ Referral Fund with Panchayats

The referral fund currently placed at the disposal of panchayats may be operationalised through Mitanins and with links to the above mentioned ambulance system. The Mitanin should be authorised to arrange the required funds for referring needy patients and even accompanying patients to PHC and CHC especially for certain categories of illness like high risk pregnancy or life threatening emergencies and so on.

## XI. INTEGRATION WITH INDIGENOUS SYSTEMS OF MEDICINE

### ❒ Need to Integrate at Level of Public Health System

Integration of the ISM structure with the mainstream public health services is desirable for a number of reasons. There is a substantial investment entailed in these systems. Utilisation is however extremely low both in terms of utilisation of ISM services and in terms of it sub-serving public health goals. By integrating the ISM network with the public health programmes a substantial income in outcomes can be expected at little extra cost.

### ❒ Defining ISM Package of Services at Each Level

Integration requires as a first step are definition of what package of services each category of personnel and facility in the ISMs would provide.

### ❒ Multiskilling ISM Personnel for Public Health Functions

Integration requires, based on the above, a multi-skilling of personnel to serve new roles, new job descriptions and administrative changes to facilitate such synergy. It also requires adequate policies of transfers and promotions and skill upgradation so that they too do not face the demotivational factors that the mainstream is already seized with.

- **Sharing Infrastructure**

  if either the ISM facility or the mainstream sector PHC does not have adequate infrastructure, a PHC building then the existing infrastructure maybe shared. Thus in working out areas of coverage priority be given to closing the gap between number of sectors and the number of PHCs . We note that if there is a synergistic deployment of the two, the current gap between number of sectors and the number of PHCs, a sum of about 238, the single largest gap in the system as identified in this study would be adequately closed by the over 579 rural ISM dispensaries that are functional.

- **Making a Common District and Block Public Health Plan**

  At the district level the district Ayurvedic officer serve as part.of the health planning committee and this plan is integrated as a subset under the district health plan of the CHMO's office and the district health society. At the block level coordination is by the BMO. At the sector level ISM facilities maybe asked to perform public health tasks in a section allotted to them. Also

## XII. TRAINING

The goal of the training policy shall be to ensure that all the requisite skills to attain a specified quality of care for a given facility becomes available at that level. This is true for para-medicals as well as for medical officers.

To achieve this goal we recommend an in-service training package with following features :

- **For Paramedicals : Multiskilling**
  - **Minimum Periodic Re-training :** The training policy must specify that every two years at least 15 days of training per MPW and health supervisor (male and female) must be received.
  - **Training Roster :** A roster of all MPWs and health supervisors should be maintained at the block and district level just for this purpose denoting last training attended, topics and number of days of training in each. The block medical officers may coordinate with district training centre to see that all their health workers have received the mandatory training.
  - **Syllabus :** The syllabus for it should be built up to include
    - Changes in health programme guidelines of national health programmes- best addressed through two day sensitisation programmes, whenever such a change is made.
    - Renewal of core area of their work – RCH programme for MPWs (at least 15 days) and national programmes for male workers.
    - Multiskilling training in which female workers learn more about national programmes and about basic laboratory skills and male workers learn about RCH and adequate levels of basic laboratory skills.
    - Adequate training for first contact curative care.
    - A modified IEC programme capability with focus on interpersonal and community mobilisation skills along with better understanding of a multicultural and ethnically diverse society.

- **On- the Job Training :** The supervisors should be held responsible for on the job training of the health workers and periodic evaluation of knowledge and skills of health workers be used to ensure that they perform this task adequately, as they should be accountable for this in their juniors. The medical officers must be equipped to evaluate the supervisors on training in most areas and in some areas like basic laboratory services they should be capable of providing the training on the job.
- **Integrate Training Funds :** All training funds from various programmes are deployed in such a way that even as the objective of that grant is realised, the training goals the state has set itself is also advanced within that same space.
- **Training Cell to Precede and Prepare for SIHFW :** A training cell for in-service MPWs and supervisors training needs to be constituted in the SIHFW that is constantly doing training needs assessment, training material development, master trainer training of district training centers, supervision of training rosters and training evaluation.

### ❒ For Medical Officers

- **Continuing Medical Education :** We recommend a Continuing Medical Education scheme for medical doctors to upgrade their knowledge and skills. This should replace the current practice of upgrading their knowledge through sporadic camps of national disease programmes. The envisaged CME scheme should also be useful for promotion purpose.[1] A CME should be pursued as a very useful intervention strategy in health care delivery system.
- **Minimum Skill-Mix for CHC :** Having defined a minimum package of services at the CHC as essential to meet public health goals one needs to a put in place a road map by which the desirable skill mix needed for delivering such a package of services would become a reality. We make the following suggestions in this regard.
  - Decide on what skill mix is needed in each CHC and what the gaps are. The focus is on emergency obstetric care but the skill mix approach need not be confined to this alone.
  - Draw up a schedule of providing short term trainings so that existing medical officers and specialists fill up the gaps with acquired basic skill sets other than in areas which their primary specialisation. Thus a surgeon may also learn to do Caesarean section or ENT and ophthalmic work, or a physician may learn paediatric functions and so on.
  - Where gaps still remain one may use public private partnerships to fill up the gaps.

## XIII. STATE AND DISTRICT LEVEL ORGANISATION

### ❒ Promotions and Tenure at the State Level

- **Prompt and Regular Appoinments :** All vacancies must be filled up at the directorate (directors, joint directors, deputy directors, chief medical officers and programme officers at the state level) must be filled up within a period of six months on a regular basis from eligible staff at that level or by promotion, (except those posts that are to be recruited from the outside

on a consultancy /contract basis where it could take upto an year). For programme officers at the district level and block medical officers must be filled up within the same timeframe but in the event of creating a separate administrative cadre where these are entry points they could take longer, upto an year.

- **Officiating Officers :** In the period between the next regular appointment and the relinquishment of the earlier appointee if an officer must be given temporary charge, then only the senior most officer may qualify for the same.
- **Security Of Tenure :** All posts of CMOs, Directors and BMOs would have a security of three year tenure. Unless there is gross failure of function certified by a panel they would not be transferred. They would be set a three year goal for development in their area when they take charge and be reviewed against these goals.

## ❒ Work Allocation and Job descriptions at the state level

- **Distribution of Work :**The four directors may have work allocations reordered so that the burden on the director of health services is reduced. This could be partly by passing some of the work to the other three directors. (For example the paramedical courses could be looked after the director medical education or the director of indigenous systems of medicine).
- **A separate Director or Seperate Body for Purchases :** Another area of devolution of powers is purchases. This devolution could be by creating a separate autonomous para-statal body to be headed by a non clinical management expert or even outsourced to a management firm to take charge of all purchases and distribution of drugs, consumables, equipment and infrastructural development. (like the Tamilnadu Medical Supplies Corporation in Tamilnadu which is headed by an IAS officer) This would free the director of health services to attend to the core administrative issues, increase oversight of programmes and take an active role in planning. Or as the last and least option- it could have an independent director in charge of purchases backed by a cell.
- **Another Director for Training, Polkicy and Planning and IEC :** Yet another area of devolution is for capability development and planning this person would also head the state institute of health and family welfare. Given the nature of the task, this director is best recruited on contract or on deputation from the open market with in house candidates also eligible to apply.
- **Specific Work Allocation and Powers for Joint Directors :** Even after such devolution the director of health services would have a very large but now potentially manageable portfolio, if there is adequate delegation of work to joint directors. The present arrangement where all of this is with the same person is a bottleneck and at high costs to the efficiency of the system. The joint directors, assisted by deputy directors, would be also given a clear charter of work with adequate powers for planning and independent action and placed in charge of specific programmes and sectors where they would have to show results. Deputy Directors would be

the programme officers at the state level as well as three who assist in core administrative issues of the directors. Their numbers may be decided accordingly.

- **SHRC and External Inputs for Planning :** We feel that this above mix of four promotees internal to the department and two recruits (on contractual/deputation basis or by the para-statal route) from the open market and the mix of skills proposed would give the much needed dynamism that a vibrant public health system needs. In addition to this or as part of this (integrated with or in conjunction with the SIHFW) formal state civil society partnership institutions like the SHRC would continue to have relevance. Planning and innovation requires fresh inputs and insights brought in from the larger academic, professional and activist circles. Contracting in directors is one avenue of such recruitment. Building state- civil society partnership insititutions like the SHRC where motivated persons with their own committemetn and intiative can contribute to the state government is another major avenue.

## ❒ Systems for purchases and infrastructure development

***The essential drug list and the norms for health services provision adopted by the state would define the minimum drugs, the minimum set of equipment and the minimum infrastructure development needed for that level of care.*** The need and challenge of developing a system of purchases is to ensure that the drug and equipment purchase of this matches and parallels the human power and infrastructure available and developing in that facility. This is not incompatible with decentralisation. On the other hand it is almost a precondition for it. The human power and expertise needed to select and finalise purchases of a bewildering range of drugs and equipment would just not be available in all districts and cannot be built up without costly redundancies. But the current centralised system is inefficient with high degree of mismatches and bottlenecks and sub-optimal in use of scarce financial resources.

***The state role is to provide for a separate office if not an institution headed by a management person with experience in procurement and supplies.*** Delegating a clinician to this is inappropriate, though close coordination with clinicians would be essential. Such an office can complete pre-qualification of companies, issues tender documents and negotiate prices and place orders on behalf of chief medical officers for all supplies- drugs, consumable and equipment. Such collective bargaining can give better prices than if each district head bargained on his own, but the requirement would be of the district. The further advantage is that by monitoring stock positions on a daily basis and linked with a distribution system the supplies of drugs can be flexible and streamlined to meet the needs of the system. The key recommendation in this is outsourcing to a management firm or a management head or a para-statal body created for this purpose headed by such a person taken on contract. This firm has to display its final rates it has secured and show comparisons with other states and public sector units to show that it has been able to get quality at rates comparable to the best deals in the nation. Quality testing of drugs and Maintenance of equipment both of which have very poor or non-existent arrangement would be taken care of by

this. It should further display the entire process on a website so that it is part of the public domain.

***In infrastructure development again this office would provide assistance to the CMO in design specifications, tendering and issuing contracts.*** Payments could be made from the CMOs office under such decentralisation.

This is not a new idea. Broadly this is what the Tamilnadu Medical Supplies Corporation has achieved and it provides consultancy for this. One may go further and seek with TNMSC or a private management firm a BOT( Build Operate Transfer )agreement building into this agreement indicators not only for building the system but also a planned capability building in the department and eventually transfer of this to a state body.

## ❒ Decentralisation and Delegation of Powers to Districts

- **The Role of Panchayati Raj Institutions:** The study group sees decentralisation as a major goal . Decentralisation is necessary to have a health plan that is flexible and responds to local needs. It is needed as a better system of administration. It allows for creativity and innovation. It allows for different rates of growth responsive to human resource s available and the quality of leadership provided. Decentralisation is however essentially a political process implying decentralisation of governance - as distinct from the mere increase in delegation of powers to CHMOs. Decentralisation of health department functions to panchayats is therefore best done as part of a process of political decnetralisation which includes increasing powers and financial resources of panchayats as well as with capability building. In the absence of such political initiative, involvement of panchayts in decision making, planning and programme implementation by placing them in district and block level committees can at best achieve capability building. This should be pursued as an interim measure.

- **Delegation of Powers to CHMOs :** This is a desirable goal for increasing the efficeincy of the system and for responsiveness to local needs. We however need to view decentralisation in the current context – where there is little innovation, where there are serious mismatches, where officers are officiating and accountability is non enforceable, where management skills are low and where administrative powers and financial resources are limited.

  Our recommendation is therefore to make decentralisation conditional on the following five features (flowing from the recommendations above) being in place.

  - The Chief Medical Officer must be a regular appointee, not officiating.
  - The Chief Medical Officer must have a minimum tenure of three years.
  - The Chief Medical Officer must have served as block medical officer or programme officer(
  - Be part of the health management cadre if this is created)and officer must have had public health management training (for ensuring capability).
  - Purchases and infrastructure development must have the state level managerial arrangements as indicated above.

- A state level body on capability building and technical advice on planning must be accessible to him/her.

If all the above conditions are satisfied then the chief medical officers powers must be enhanced to a level where it includes modifying and creating his own health programmes based on the district health plan and seeking budgetary support for it. The administrative powers of the CHMO must be at least that of the joint director. All purchases required to reach recommended norms of service delivery, district level recruitment of staff, promotions and training to reach service delivery norms should be incrementally brought under the district powers along with technical support arrangements from the state level.

In the absence of the above five criteria being realised the existing powers are perhaps what is optimal, along with rigorous supervision.

## ❒ The Development of a Health Administrative Cadre

- **Need for Two Cadre Streams :** Some clinicians are not interested in or resent administrative work but cannot refuse the offer for it is related to seniority and status. There are some who would want to undertake administrative work, would prefer this for their career and would be happy to get themselves qualified in this area. But to give up clinical work especially in the private practice domain is a loss of both professional status and income. These contradictions need to be resolved pragmatically by charting two career streams – one clinical and one administrative.

- **The Health Adminstrative Stream :** A health administrative cadre may be created of all the persons working as BMOs, CMOs, District and State Programme Officers, and officers in the training institutions. All would be class I officers. These persons are paid 25% or such of salary as non practising allowance and forbidden from practice. They are further given a travel allowance for supervision work if not provided with a vehicle. Their opportunities of promotion are easier and they may even become class I earlier, but they would have more transfers and would have to serve in difficult areas first. They would get one year training over two or three spells – in management, in public health and epidemiology and health planning. They could be eligible for a one year sabbatical once in six years. They would be part of a state cadre.

- **The Clinical Stream :** Those who opt for the clinical stream get no allowance and face less transfers. They have little promotion avenues though specialised training can enhance their clinical skills. They can however rise to head district and sub-district civil hospitals as civil surgeons and with hospital administration training go onto being medical superintendents of tertiary care hospitals. The civil surgeon would serve under the CHMO so that there is a clear chain of command especially as the specialists posted there are needed for public health

functions in other facilities. However they would have considerable autonomy over hospital management. Alternatively the post of civil surgeon can be abolished. Those in the clinical stream can opt to be part of a district cadre.

- **First Ten Years-Common Cadre :** The details have to be worked out by a committee. The general principle is that for the first ten years everyone is of a common cadre and then they choose one of two career plans, both with their own attractions.

## The Post of the BMO

- ***The BMO Should be Made a Designated Post.*** It should be the mandatory entrance point into the administrative cadre. It should require a minimum of 10 years of service to become a BMO.
- Since the creation of a medical administrative stream within is a difficult decision to make, a number of immediate steps are also suggested. These include
- A three-day ***induction orientation*** conducted at state level, every quarter, for all BMOs who are appointed in that quarter. This orientation helps them learn all the basic programmes and the administrative issues that they have to handle.
- The ***development of annual block level plan*** with guidance where they identify their goals and plan their activities and mark out the constraints in equipment, drugs infrastructure etc for action by the district.
- ***A provision of a block medical officer honorarium/allowance*** if we are able to ensure
  - Tenure of at least three years.
  - That this is not seen as an opportunity for generating private earnings – for themselves of for sleaze within the system.
  - That the BMO assignment is linked to developing and implementing a measured and monitored block level health plan.
  - If tenure is assured to also insist on every BMO completing a three month distance education programme on management aspects arranged by the state government in collaboration with some institution with expertise in health management.
  - Empowering BMOs with powers and support from the CMO and state office required to affect their block level plans including the provision of an adequate imprest fund and basic modern office support.

## District Programme Officers as Deputy CHMOs

The post of programme officers should be seen as assistants to the CHMO and be part of the administration cadre. Instead of designating them in an adhoc manner each district may have four officers to assist the CMO who would hold largely administrative "Deputy CMO" function. These could be a programme officer for RCH programmes including immunisation and family welfare, another for all other national programmes, a third for training and IEC functions who is in charge of the district training centre, and a fourth for purchases, distribution, logistics of

all supplies and infrastructure. Along with the CHMO and with adequate administrative and office support this would be a viable district leadership team. It needs to be emphasised that all the five are trained in public health and ideally form part of an administrative cadre.

### District Chief Health and Medical Officer

The Chief Medical Officer should necessarily be a regular appointment on promotion, with adequate training and experience working as both programme officer and a block medical officer and assured of three-year tenure at least. In such a context more powers can be delegated to this post.

## ❐ Development of management skills & The development of planning capability

If ***mandatory training*** is introduced for all district programme officers and chief medical officers and deputy directors we would get eventually get more planning capable staff in the directorate. ***A three-month health management course*** by a national institute done by correspondence would be the basic minimum qualification needed.

It is also important to ensure that all those who become joint directors or directors have served as district chief medical officers and that all deputy directors and CMOs have worked as BMOs or district programme officers.

Development of planning capability in the directorate also requires further ***inputs from operational research and from epidemiological work.*** Understanding the rigour of this by participating in this or at least using such reports consciously needs to be built in. Without such experience planning is arbitrary, unscientific and becomes an expression of power relationships with dependence on externally made and poorly adapted programme designs.

Further, in the current context, ***opportunities for interaction with that section of NGOs who are active in health advocacy*** or community action at both national and state level is essential to develop a critical insight into ones own mindset and to critically evaluate programme designs.

## STRATEGIES FOR IMPLEMENTATION

Much of the above recommendations are already recognised by health administrators. They have however not been implemented because they are linked to issues of governance and larger systemic changes. However not all the changes proposed require political action or will be denied such sanction. The study group would like to go further and propose three key parallel strategies of implementation so as to maximise what can be done in the current context.

### STRATEGY – I

#### EQUIP (Enhancing Quality In Primary Health Care)

The most important and recurring dimension of the study report is the problem of quality of care and the current inadequte perception of the problem. Thus sector PHCs' report drug situation as satisfactory when half the essential drug list is unavailable there, the importance of the laboratory to the practice of medicine is almost forgotten, sanitation inadequacy is not perceived, beds are not covered with linen and so on. Better infrastructure, Better Manpower situation and Better provisioning of centers with supplies does not add upto better quality of care and this failure is one reason why both public and internal demand for improved public health systems has become muted. The mix of organisational, motivational and leadership factor that have to be addressed are "soft" issues from the viewpoint of administration and require a different approach than mere administrative diktat.

However simultaneously one does need to close gaps in supplies, equipment and infrastructure. Attempts to close such gaps across the whole state as one effort, driven by a big purchase or a single order, has led to lot of mismatches and redundancies in the past. Inability to provide adequate state level supervision and skill development to match such hardware improvements has worsened the mismatch and redundancy situation.

***We therefore suggest that a Quality driven approach to provisioning of health facilites to be initiated in a set of blocks , then expanded to more blocks in phases till the whole state is covered. These block level plans would make full use of this study and its recommendations and try to address many of the concerns in the following steps :***

- **Block Level Plans :** In a given block a planning resource group helps the block draw up its health priorities by beginning with a situational analysis, which would include assessing quality levels against a set of standard reference norms.
- **Goal Setting (With Focus on Obstetric Care) :** Goal setting at the block level is then undertaken for each national programme and for local health priorities. Goals are set in a participatory manner, not only on numerical targets, but also on quality of care. The focus is on building a team approach under the BMOs leadership to achieving goals set by themselves in a facilitatory environment. Special focus is given to ensuring emergency obstetric care including Cesarean section at the CHC, 24 hour institutional delivery at the PHC and quality antenatal and post natal care at the subcenter level.

- **Closing Infrastructure Gaps :** Identifying infrastructure deficiencies and under-utilisation and closing these gaps on a priority basis .Planning optimal location of sub-centers and PHCs and organising relocation especially where there are no buildings or buildings are not in use. A GIS based database of current distribution should be made available to facilitate this.
- **Closing Equipment Gaps :** Identifying equipment required and supplies required and closing these gaps along with skill development and maintenance arrangements needed
- **Multiskiling :** Redefining work allocations of all staff ( who are increasingly multi-skilled) based on facilities' needs and their own effectiveness in various tasks. Skill development in existing staff so as to provide minimum skill -sets needed at each facility and so that there are no staff with redundant work time.
- **Closing Mapnpower Gaps :** Identifying manpower gaps that remain after multi-skilling and closing them both by recruitment and transfers on a priority basis ISM integration : Integration of all institutions of indigenous systems of medicine in the block into the block level plan and building skill sets needed for them to be able to contribute effectively to public health goals. Sharing infrastructure and manpower for specific public health goals especially in women and child health care.
- **Public Private Partnerhsips :** Building in public private partnerships where even with all above measures there remain gaps between the recommended norms of service delivery.
- **Referral, Ambulance and Laboratory Services :** These are to be built up in block level , where needed with public private partnerships so as to provide the systmic interlinkages that would make for effective primary health care in the block.
- **Moniotring and Evaluation :** In synergy with all the above ensuring the services delivery in the block, in every facility keeps improving ,both in quantity and quality. This requires tight monioting, support and concurrent evaluation of progress towards physical and quality goals at the end of the year based on indicators developed by the block team.

Since this programme is about closing gaps through matched resource and skill inputs a good name for this (an effort already being initiated) is EQUIP- Enhancing QUality In Primary Health Care Services

We note that this is very useful way of developing district level capabilities and district level plans that can set the stage for effective decentralisation. It would also build up administrative and planning capabilities in the block medical officer who is at the cutting edge of all programme implementation. It would also ensure full utilisation of existing manpower and infrastructure and equipment.

We note that all the steps in this are possible within existing policy frameworks and one only requires the sanction to proceed block by block in a comprehensive manner. Administrative changes as suggested below and a state team to facilitate this process would be

## STRATEGY - II

### Intermediate level of Operationalisation : The Administrative

Many other recommendations of this study are amenable to such immediate administrative action at the state level and should be converted into specific proposals for the purpose. These may be listed as follows :

- **Creating a Cadre of Multi-Skilled Paramedical Workers**

  Today more than half of the posts of paramedical workers in a PHC are vacant. However those who are posted there are often under-worked. A dresser posted in a PHC hardly ever gets more than 2 to 3 patients a day. On the other hand the PHC is not able to perform even routine laboratory tests because it does not have a laboratory technician. Multi-skilling of paramedical workers is therefore recommended, so that the entire package of services can be delivered in a PHC using the existing manpower. This may go along with merging and redefining dxisting cadre and declaring many existing cadre as dying.

- **Gradually Replacing the Male Health Worker with the Female Health Worker**

  There are large vacancies of Male Health Workers in the State. Our study shows that the Male Health Worker essentially works as a support to the Female Heath Worker. Female Health Worker performs most of the Public Health tasks. The need for having two Female Health Workers in each HSC has long being felt. It is there fore recommended that all vacant posts of Male Health Workers be filled up with Female Health Workers, and the cadre of Male Health Workers be declared a "dying cadre". Eventually each HSC will have only two Female Health Workers and no Male Health Worker

- **Creating a Women Employees' Assistance Cell at the District Level**

  A women employees' assistance cell should be created at the district level, to address the personal security issues of female staff especially the female multipurpose worker.

- **Building up Laboratory Services**

  Laboratory services at the PHC level should be based on multi-skilled workers and at the CHC level with qualified laboratory technicians. At both levels the recomendation is for expanding the set of diagnostics as laid down in recommended norms of service delivery for every level with public private partnerships to fill in gaps where needed.

- **Logistics Support for Consumables**

  It is recommended that a transparent and effective mechanism should be adopted for management of supplies. A mechanism similar to that followed in Tamil Nadu by TNMSC could be followed.

- **Multi-Skilling of Doctors for Emergency Obstetric Care**

  The clinical skill-sets- especially as related to emergency obstetric care, needed in a CHC should

be defined and a programme of training doctors so that in a time bound manner all CHCs have the desired skill-sets should be initiated.

### ❒ A Fair Transfer and Promotion Policy

Major recommendations in this regard are : -

- Transfers should be done at the district and state level by district and state level tribunals. All staff should serve for roughly equal time in postings categorised as of being of three levels of difficulty. Places of postings should be categorised into grade A, B and C according to the increasing level of difficulty. Employees may even be allowed a choice in the matter postings within the same grade of difficulty.
- Reducing pressures for transfer by making ***MPW selection into a block level cadre*** and other category selection including medical officers other than class I officers into **district cadres.**
- ***One time bound promotion for all cadres.*** However 25% of posts of the supervisor cadre should be reserved for a fast track promotion based on merit, and willingness to work in difficult areas.
- For medical officers adopting ***a promotions policy for class I doctors, consistent with two alternative career plan options.*** One leading to an administrative work definitions and another to more clinical work. Thus we should have two separate streams at class-1 level and above, one clinical and the other administrative. Those who are good clinicians, but are not interested in administration should be given a career choice in the clinical stream with sufficient promotion opportunities. Those who choose the administrative stream, should receive good training in administrative and management matters, and should also have equally good promotion opportunities.
- Designating ***the block medical officer as a distinct cadre,*** and entry point into an administrative cadre with well-defined job allocation and administrative and financial powers. Ensuring that all of them receive a three-month management-skill package.
- ***Constitution of the district team*** as made up of a Chief medical officer along with four full time programme officers who are part of the administrative cadre and serve as deputy CMOs. In parallel to this ensuring that all these posts are regular appointments with tenure and that there are state level support systems in place.

### ❒ Capacity Building and Human Resource Development

- **Adopting the training policy for all staff** whose main component is ensuring that all staff receives 15 days of in-service training every two years so as to ensure that minimum competencies for that facility level are present and updated. The requirement of training infrastructure is defined by this need.

- **Initiating an innovative CME programme** as the main stay of training for the medical officers along with a mechanism of managing the CME.
- **Disseminating and training** medical officers and specialists on standard treatment guidelines as well as the norms of clinical services provision that the government is committed to.
- **Expanding in-service training infrastructure** to 16 District training centers, three regional training centers, a state training center, and two medical college based training centers.

❐ **State Level Organisation**

- **Restructuring state health society** (including re-thinking the need for its continuation -in comparison to directly functioning all programmes a part of the state budget) to make it more functional and accountable.
- **Strengthening state level function by de-concentration and decentralisation** and a more distributed work allocation between expanded numbers of senior personnel. Senior cadre should have a guaranteed tenure, a clear work profile and a personally affixed sector development goal that they have to meet in this period along with adequate powers that enable them to take initiatives where needed.

## STRATEGY – III

### Highest Level of Operationalisation : the Legislative

In a democracy the highest level is always the political level. Unfortunately issues like quality of health care or issues of human resource development do not from part of the mainstream political discourse. The compulsions on political forces cutting across ideologies and parties are such that there is considerable "public pressure and support" for certain types of interventions like building a 100 bedded hospital when on the other hand most 30 bedded hospitals in the same area are underutilised. The non- recurrent component of an AIIMS hospital costs as much as the entire state health annual budget, but it can win cross party political support. But a fair transfer policy that is essential to ensure that remote areas are better staffed has no political spokesperson for it. Public private partnerships for advanced tertiary care centers are easier to realise then partnerships at local levels for basic laboratory or midwifery services.

However we must recognise and build on the already available and widest possible consensus across all ideologies and economic philosophies that health care for the poor is the responsibility of the state. The government of Chhattisgarh shares this commitment in no small measure and as the events of the last few years show is willing to follow through with bold initiatives. However there are political compulsions that influence the current state of public health policy and these compulsions are such that any sustaining any initiative by administrative action alone is too fragile to guarantee sustainable health sector reform. One needs reforms of a particular period to have a permanence across new administrative and immediate ministerial dispensations.

The committee therefore recommends the enactment of a suitable legislation called the **Public Health and Health Services Act** of the state of Chhattisgarh. Such legislation is needed

for marking the acceptance of the government to the existence of basic health care services as an inalienable human right. This study indicates that unless minimum norms of health service delivery are laid down and minimum norms of governance needed to secure this right for its citizens are enforced this right would remain on paper.

The Supreme Court has held that the government has a constitutional obligation to pro vide health facilities (State Of Punjab vs Mohinder Singh Chawla(1997)2SSC83,) and therefore to maintain adequate health services (State of Punjab vs RS Bagga-(1998) 4SSC 177. *The need is to take the legal situation created by these rulings further with a codification of what adequate health services are and the minimum conditionalities of a public health care system that can be said to be fulfilling the obligation of the state. In the absence of such guidelines every case of denial of the right to health care services would appear to be the individual blame of the concerned doctor or staff and the systemic failures would go unchallenged and administrative and political accountabil ity would be limited.* A public health act however is enforceable while retaining considerable ad ministrative and political flexibility is how it is implemented.

Such a public health services act would :

- Define a mechanism for laying down and periodically revising the norms of health services and facilities and supplies that the government would provide at every level- such that it is compatible with existing Supreme Court rulings and the right to life. Flowing from this would be the needs of the workforce, infrastructure, drugs, supplies and equipment needed.
- Define core administrative mechanisms that must be in place for ensuring effectiveness and accountability of the system.
- Define the regulatory mechanisms for ensuring the quality of care and effectiveness of care and ensuring the ethical nature of such services whether it be provided by the public sector or through public private partnerships.
- Include mechanisms of civil society oversight over the system understanding that health is too important and too close to everyone's lives to be left to the workings of a department alone.
- Codify the state's commitment to a community health worker programme so as to provide access to minimum essential drugs and services at the habitation level.
- Define a broad policy for encouraging the provision of ethical care by the private sector in health so that its ethical and rational growth is encouraged and there is some measure of access to weaker sections of society.

The creation of such an act requires a close cooperation with a wide range of public health expertise and legal minds and an active role for civil society. The passing of such an act by the state assembly would also help to sensitise the legislature to the issues of health sector reform. It would help secure the minimum norms of governance neded for citizens to enjoy the right to health and health care.

State Health Resource Centre is an autonomous institution funded by the state government as part of the sector investment programme. It is functioning as additional technical capacity to the Department of Health and Family Welfare, Govt. of Chhattisgarh. The SHRC is a joint initiative of the State Government of Chhattisgarh and Action Aid India. Other than the Mitanin Programme, the SHRC is initiating a wide range of activities as part of the Health Sector Reforms Programme and as part of its contribution to strengthening public health systems for achieving comprehensive universal primary health care.